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Members of the Nevada State Legislature
Legislative Building
Carson City, Nevada

The purpose of this letter is to summarize the results of the Legislative Auditor's review of child fatalities and near fatalities when a child welfare agency had prior contact with the child or family. Pursuant to Nevada Revised Statutes (NRS) 218G.550, we reviewed case files provided by child welfare agencies between January 1, 2019, and December 31, 2020.

Results in Brief

In 3 of 56 cases reviewed, we had concerns about the agencies' actions prior to the fatality or near fatality. In one case, we found a child welfare agency did not initiate an investigation after multiple reports of possible abuse and maltreatment were made, and deferred investigations to law enforcement. In another case, we noted an agency did not investigate law enforcement's report of potential neglect. Finally, we observed a case where a child welfare agency did not follow state law and appropriately document the report and investigation of child abuse in the centralized child welfare system. After expressing our concerns, agency officials have since provided additional training to staff, and made changes to policies and procedures to reduce the risk of these issues occurring in the future. Additional information is provided below concerning the number of fatalities and near fatalities and the results of our case reviews.

Introduction

Several bills passed during the 2007 Legislative Session to improve child welfare services in Nevada, including Assembly Bill 261. This bill included a requirement, effective July 1, 2007, for child welfare agencies to submit to the Legislative Auditor case files of children who suffer a fatality or near fatality, if the agencies had prior contact with the child or family. The Legislative Auditor is required to review the information to determine whether: (1) the case was handled in a manner consistent with state and federal law, and (2) any measures, procedures, or protocols could have assisted in preventing the fatality or near fatality. This requirement is codified in NRS 218G.550. Our case file reviews were not audits; therefore, the reviews were not conducted in accordance with generally accepted government auditing standards.

Our work consisted of reviewing case information stored electronically in the centralized child welfare system and copies of the case files provided to us by the child welfare agencies. We also discussed the cases with personnel from the child welfare agencies when necessary.

These procedures enabled us to obtain an understanding of agencies' actions concerning the families prior to the fatalities or near fatalities.

Number of Fatality and Near Fatality Incidents

From January 1, 2019, through December 31, 2020, we reviewed 121 case files of children who suffered a fatality or near fatality where a child welfare agency had prior contact with the child or a member of the child's family. In 65 (54%) of the cases, the child welfare agencies determined that abuse or neglect was not the primary factor in the fatality or near fatality. These 65 incidents were caused by other factors such as conditions due to congenital medical issues, SIDS, co-sleeping, suicide, or other accidents. The following table provides a breakdown of the remaining 56 case files we reviewed where abuse or neglect was found to be a primary factor in the fatality or near fatality, from each of the child welfare agencies in Nevada (Clark County Department of Family Services [DFS], Washoe County Human Services Agency [HSA], and the Division of Child and Family Services [DCFS] – Rural Region).

Abuse or Neglect Fatalities and Near Fatalities of Children Having Prior Contact With Child Welfare Agency January 1, 2019, to December 31, 2020

Agency	Number of Fatalities	Number of Near Fatalities	Totals
Clark County DFS	21	24	45
Washoe County HSA	5	2	7
DCFS – Rural	3	1	4
Totals	**29**	**27**	**56**

Source: Auditor compilation based on records provided by child welfare agencies.

Results From 2019 and 2020 Case Reviews by the Legislative Auditor

In our review of 56 cases, there were 3 where we expressed concerns to child welfare agency officials about how the cases were handled. Each of those cases is explained further below, along with a summary of the agencies' responses to our concerns, including actions the agencies have taken to reduce the risk of these issues occurring in the future.

Reports of Potential Maltreatment and Sexual Abuse Not Investigated

After reviewing the case file of a child who suffered a near fatality in October 2019, we observed that prior to the near fatality Clark County DFS did not initiate an investigation into reports of potential maltreatment and sexual abuse, and sometimes deferred investigation of the reports to law enforcement. Statewide Intake Policy 0506, in effect at the time, required reports

of sexual abuse to be investigated immediately if the child was 5 years of age or younger. In addition, this policy also required supervisory review when a third report of maltreatment would otherwise be screened out. Prior to the near fatality, Clark County DFS received six reports of potential maltreatment or sexual abuse that were screened out and not investigated. For two reports, agency case notes indicated information was reported to law enforcement or made reference to potential action by law enforcement, but no additional action was taken by the child welfare agency. Although law enforcement is sometimes involved when there are allegations of abuse or neglect, child welfare agencies are tasked with different responsibilities, including the assessment of the functioning of children's caregivers and the safety and welfare of children within their living environments.

We expressed these concerns to Clark County DFS officials who agreed that individual reports of abuse or neglect should not be reviewed in isolation of other case information, and a case needs to be reviewed in its entirety. In addition, they indicated staff had an over-reliance on law enforcement to conduct an investigation and report back before the agency would take action. The agency reports this approach has ceased and direction has been given to staff that reports should not be deferred to another agency for the purpose of gathering additional information. Furthermore, Clark County DFS now requires an additional supervisor to review decisions to not investigate when there are reports involving children under 3 years of age, and when multiple reports have been screened out in the prior 2 years. We will continue to monitor the agency's implementation of its new practices on future case reviews.

Reports of Neglect and Diminished Caregiver Capacity Not Investigated

In one case we reviewed, a teenage child suffered a near fatality in October 2019 after overdosing on cocaine and other drugs. Prior to the near fatality, Clark County DFS received a report from law enforcement that the child had not been enrolled in school since June 2018, regularly used drugs, and was cited for possession of a controlled substance and intent to sell. Furthermore, it was reported the child's caregiver recently suffered a brain injury and was experiencing mental health issues. However, Clark County DFS staff did not investigate this report because they did not have sufficient information regarding the functioning of the caregiver, and believed the Department of Juvenile Justice Services (DJJS) was managing the child's behavior. When the functioning of a caregiver is not assessed, a child welfare agency does not know if the reported neglect is due to the faults and habits of the caregiver or the child.

After expressing our concerns, agency officials indicated there have been concerted efforts to collaborate with the Clark County School District and the DJJS to address the needs of families that are being served by all agencies. In addition, Clark County DFS recently implemented a new policy and procedure to help assess educational neglect, and provided additional training to staff. We will continue to monitor the agency's implementation of its new policy and procedure on future cases.

Investigation Not Documented Properly

After reviewing the case file of a child who died in April 2020, we concluded the Washoe County HSA did not properly document the receipt and investigation of alleged sexual abuse. A few years before the fatality, Washoe County HSA received a report of a child-on-child sexual abuse in which there were concerns the foster care provider was negligent and did not properly monitor a child. NRS 432B.310 requires a child welfare agency investigating a report of abuse or neglect to document the investigation and disposition of the case in the Central Registry upon completion. Instead of documenting the report and subsequent investigation in the Central Registry, Washoe County HSA only recorded this incident and the investigation in its foster care licensing files. When reports of abuse or neglect are not documented in the Central Registry, there is greater risk that important information will not be known that would help the child welfare agency, law enforcement, and the State correctly assess the safety and welfare of children living with their caregiver(s). Although it is unlikely the issue mentioned above directly contributed to the death in this case, there is potential it could affect the safety of other children in the future.

We expressed our concerns to Washoe County HSA management who indicated various policies and procedures have been updated since the incident. These changes further clarify how reports of abuse or neglect in a foster home will be handled, including review by a supervisor. As we perform case reviews in the future, we will continue to monitor the agency's efforts to ensure any potential reports, and subsequent investigations of abuse and neglect in a foster home placement are correctly documented in the Central Registry.

We would like to express our appreciation to personnel at Clark County DFS, Washoe County HSA, and DCFS for their cooperation, and recognize their continued efforts to protect vulnerable children in our State.

Please contact Todd Peterson, Audit Supervisor, or me at (775) 684-6815 if you have any questions regarding this letter.

Sincerely,

Daniel L. Crossman, CPA
Legislative Auditor

DLC:da
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